DWS-OSD 61M
Rev. 10/2007

State of Utah
Department of Workforce Services
APPLICATION FOR MEDICAL ASSISTANCE

PLEASE USE A BLACK BALL POINT PEN TO COMPLETE FORM

Case#: _____ PID#: _____

Your Information:

1. Fill out the following information for the **person requesting benefits.**

Name: _____
First Middle Last

Home Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Phone#: _____
Home Work Cell

2. Starting with yourself, list all the people **who live in your home:**

** *You do not need to list the Social Security # or Citizenship of any household member who does not want medical coverage.*

Name	Relationship	Marital Status	Sex	Race/ Ethnicity*	Birth Date	Age	Student Y/N	Social Security# **	Utah Resident Y/N	US Citizen Y/N**
	Self									

*Ethnicity
H = Hispanic or Latino
N = Not Hispanic or Latino

*Race
AI = American Indian or Alaska Native
AS = Asian
PI = Native Hawaiian or other Pacific Islander
WH = White

3. Do you have medical bills in the last 90 days: ……..☐ Yes ☐ No
*If yes: Name:*_____ *Dates of Service:*_____

4. Has anyone received Financial Assistance in the past 4 months? ……..☐ Yes ☐ No
*If yes: Name:*_____ *When:*_____ *Where:*_____

5. Is anyone in your household pregnant or been pregnant in the last 90 days? ……..☐ Yes ☐ No
*If yes, who:*_____*expected due date*:_____

If pregnant, have you smoked or used tobacco in the past 6 months? ……..☐ Yes ☐ No

6. Is anyone unable to work or has a major medical need? (injury, illness, cancer, kidney disease, etc)
*If yes, explain:*_____

7. Has anyone in your household ever served in the military?.....☐ Yes ☐ No
*Name:*_____ *Date:* _____

8. Has anyone in your household been determined disabled by Social Security?.....☐ Yes ☐ No
*Name:*_____ *Does this person pay child support/alimony?*.....☐ Yes ☐ No

Name and amount paid: _____

9. Has anyone been in a jail, hospital or nursing home for 30 days or more within the last 3 months?..... ☐ Yes ☐ No
*If yes, explain:*_____

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Personal Assets:

10. Do you or anyone applying with you have any of the following financial assets?..... ☐ Yes ☐ No

- $ _____ Checking Account
- $ _____ Savings Account
- ☐ IRA
- ☐ Stocks
- ☐ Bonds
- ☐ Annuities
- ☐ Time Certificates
- ☐ 401 K / Other Retirement
- ☐ Money Market Funds
- ☐ Trust Funds
- ☐ Other: _____
- ☐ None

11. List all vehicles owned by you or anyone applying with you. Some examples are cars, vans, trucks, boats or water craft, motorcycle, snowmobiles, motor homes, ATV's, etc.

Registered Owner(s)	Type	Make	Year	Licensed Y/N	State	Amount Owed
						$
						$
						$

12. Do you or anyone applying with you have any of the following assets?

- ☐ Home
- ☐ Life Insurance
- ☐ Burial Plans/Funds
- ☐ Campers
- ☐ Time Shares
- ☐ Tools
- ☐ Rental or Investment Property
- ☐ Life Estate
- ☐ Land
- ☐ Mineral or Timber Rights
- ☐ Cemetery Plots
- ☐ Trailers
- ☐ Livestock
- ☐ Other: _____
- ☐ None

Income:

13. Do you or anyone applying with you have any of the following **unearned income**?

- ☐ Social Security
- ☐ Retirement
- ☐ SSI
- ☐ Workers' Compensation
- ☐ Unemployment
- ☐ Child Support
- ☐ Alimony
- ☐ Lump Sum Payments
- ☐ Inheritances
- ☐ Settlements
- ☐ School Financial Aid
- ☐ Veterans' Benefits
- ☐ Other: _____
- ☐ None

14. Does anyone applying with you have **earned income**?..... ☐ Yes ☐ No

If yes, provide information below:

Name of Person Working: _____ Hourly Rate: $ _____
Employer Name: _____ Hours Worked Weekly: _____
Self-employment: ☐ Yes ☐ No Monthly Amount: $ _____

Name of Person Working: _____ Hourly Rate: $ _____
Employer Name: _____ Hours Worked Weekly: _____
Self-employment: ☐ Yes ☐ No Monthly Amount: $ _____

15. Does an employed person pay for dependent care so they can work?..... ☐ Yes ☐ No

Who and how much: _____

16. Does anyone expect changes in earnings or number of hours worked?..... ☐ Yes ☐ No

If yes, e*xplain:* _____

17. Does anyone in your household receive help with rent, food, or utility bills **OR** work in exchange for rent, food, or utility bills?.....☐ Yes ☐ No
*If yes, explain:*_____

18. Has anyone in your household applied for, received, or been denied SSI, SSA, VA, Unemployment, or Worker's Compensation?.....☐ Yes ☐ No
*If yes, explain:*_____

19. Please complete the following sections:

Client Information	**Name:** _____ **Case#:**_____ **Date:** _____
Check the appropriate box.	**Insurance Information** - If anyone in your home is currently enrolled in health insurance, has insurance available which you have not enrolled in, or if anyone in your household has insurance that has ended in the past 6 months, complete this section. *(DO NOT list Medicaid, Medicare, CHIP or PCN.)*
☐ Enrolled ☐ Not enrolled but available ☐ Ended, Date ended	Name of Insurance Company_____ Phone #_____ Address of Insurance Company _____Group # _____ Policyholder Name _____ Policy # _____ Policyholder Date of Birth _____ Policyholder Social Security # _____ If insurance is through an employer, list employer name and phone _____ Premium $_____ Date Due_____ How Often? _____ Names of Individuals Covered (if not listed on the insurance card):_____ _____
☐ Enrolled ☐ Not enrolled but available ☐ Ended, Date ended	Name of Insurance Company_____ Phone #_____ Address of Insurance Company _____Group # _____ Policyholder Name _____ Policy # _____ Policyholder Date of Birth _____ Policyholder Social Security # _____ If insurance is through an employer, list employer name and phone _____ Premium $_____ Date Due_____ How Often? _____ Names of Individuals Covered (if not listed on the insurance card):_____ _____

Check the type of incident:	**Accident, Assault or Other Liability** - If any household members have been injured in an accident, assault or someone outside your household is required to pay for medical services, complete this section.
automobile dog bite assault slip/fall work-related other* medical malpractice	Name of household member:_____Date of incident:_____ Who is responsible? _____ Phone #: _____ Police department: _____ Police Report #: _____ Name of Attorney: _____ Phone #: _____ *Explain other: _____

BEFORE YOU SIGN THIS APPLICATION, BE SURE YOU UNDERSTAND THIS INFORMATION

You must initial each paragraph!!

( ) I assure that all of the members of my household are U.S. citizens or aliens in lawful immigration status, unless I am requesting emergency medical assistance only. The Department of Health will verify alien registration numbers with the Immigration and Naturalization Service (INS). The Department will not report undocumented household members to INS.

( ) All the members of my household will obey the medical assistance program rules. If I receive medical assistance which I am not eligible to receive, I will be responsible for repaying the medical assistance. I will allow only the people named on the medical card to use the medical card. I understand that these rules apply to my current household as well as others who may become eligible later.

( ) If the Utah Department of Health pays for my medical care, I assign to it my rights to payments from any third party and to benefits for medical services. I will give to the Department any money I collect from an insurance policy or from someone required to pay for my medical expenses. I authorize payment directly to the Department of Health or the Office of Recovery Services and will hold harmless any party making payment to them. I agree to cooperate with the State of Utah to establish medical support for my family and in pursuing any third party responsible for medical expenses. I agree to cooperate with the State of Utah to establish and collect alimony and child support for my family unless I have good cause.

( ) I agree that the assistance I receive under any medical program is limited to that described in the Provider Manuals that the Utah Department of Health has written. I understand that the benefits I am eligible to receive may be changed without my knowledge or consent. I further agree to be responsible for any co-pays to providers at the time of medical service unless I am exempt from those co-pays.

( ) I authorize any person or organization to release medical records or information about my health or the health of my dependents to the Department of Health, Division of Health Care Financing or designee. The Department of Health and the Department of Workforce Services may give health care providers information about my eligibility for medical assistance.

( ) The State has the right to recover from my estate all money spent to pay my medical bills if I receive Medicaid at any time while I am 55 years of age or older.

( ) I will tell the State about any annuities that I or my spouse have an interest in. I understand that the state becomes the beneficiary of any annuities if I or my spouse receive Medicaid for Nursing Home or Waiver services.

( ) I give permission for ANY INFORMATION LISTED ON THIS FORM TO BE VERIFIED. My medical benefits may be reduced, denied, or stopped because of information received. I understand that failure to report changes and any false information given on this application, or subsequently provided, may result in prosecution for fraud. I understand that I may ask for a fair hearing if I disagree with the decision made on this application. For more information on fair hearings see your Rights and Responsibilities on the next page.

( ) I have been given a copy of the Rights and Responsibilities and Change Reporting Requirements. I have read and agree to the terms stated on these forms.

I give permission for the following person(s) to act as an authorized representative and have access to the information in my case:

Name:_____	Name:_____
Address:_____	Address:_____
Phone#: _____ Relationship:_____	Phone#: _____ Relationship:_____

**** *I (print name) _____, read or had read to me the statements on this page. I understand those statements. Under penalty of perjury, I swear that the answers I have given on this application are complete and correct. I am the person represented by the signature on this document.*

_____ _____

Signature or Mark of Applicant Date

_____ _____

Signature of Spouse or Authorized Representative Date

- Voter Registration: If you are not registered to vote where you live now, would you like to apply to register to vote here today?..... ☐ Yes ☐ No

(If you do not circle either Yes or No, you will be considered to have decided not the register to vote at this time.)

- If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided.
- If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Lt. Governor, State of Utah, 203 State Capitol Building, Salt Lake City, UT, 84114.

** Please tear off this section for your information. **

Your Rights and Responsibilities

Your have the right to:

☐ Apply or reapply any time you wish for any medical program. Applications for PCN, CHIP and UPP are only accepted during open enrollment periods. If you need help, someone will help you apply.

☐ Receive a notice that we have either approved or denied your application and the reasons for the decision. For medical assistance, we have 30 days to process your application. We have 90 days if you claim to be disabled, unless you need more time.

☐ Receive a notice if we reduce, stop or hold your assistance and why. In most cases, we must mail the notice 10 days before we do this.

☐ Do the following things if you do not agree with decisions made regarding your case:
A. Talk to your worker. Make sure you are not misunderstanding each other.
B. Talk to your worker's supervisor.
C. Talk to Constituent Services, (801) 526-4390 or call toll-free 1-800-331-4341.
D. Request a Fair Hearing within 90 days of the decision; 10 days to get benefits while the hearing is held. If you were denied disability status, you may also ask for a reconsideration as part of the fair hearing. If SSA denied your disability, you would have to go through their appeal process.
E. Request legal representation regarding your fair hearing. You may be entitled to free legal assistance from Utah Legal Services. In Ogden, 394-9431; Salt Lake, 328-8891. The toll free number is 1-800-662-2538. You may also receive a referral for legal advice from the Salt Lake Lawyer Referral at 531-9075.

☐ Look at information in your case. Information about you and your case is confidential. Information may be given to other agencies to administer a program to help you.

Your Responsibilities:

☐ **Verify Information**

The Social Security Act (U.S.C. 1320 b - 7 (a) (1) requires that you give us a Social Security number for each household member who wants medical assistance. If you do not have a number, you must prove you have applied. You may be eligible for assistance while you are waiting to receive a number. If you are applying only for emergency Medicaid, you do not have to have a Social Security Number.

Your Social Security number will be used with the State Income and Eligibility Verification System to make sure that your household is eligible for federal assistance programs. Computer matching, program reviews, and audits will be done with Job Service, Immigration and Naturalization, Social Security, and Internal Revenue Service records. We may also do inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about your household. You must give us proofs to show that you are eligible for assistance. The Department will not report undocumented household members to INS.

☐ Children enrolled in Medicaid are automatically enrolled in the Utah Statewide Immunization Information System (USIIS). If you do not want your children enrolled in this system, you must call the USIIS HelpLine at 801-538-6872 or the Immunization Hotline at 1-800-275-0659.

☐ **Cooperate**

You must cooperate in any review of your case by Quality Control, Recovery Services, and the Department of Workforce Services. You must also cooperate in providing information about any other sources of medical payments and obtaining medical support. If you feel you could be harmed by giving this information, you can request a 'good cause' claim. Your worker can explain this procedure.

You and your household must also obey the medical assistance program rules.

DWS-OSD 476
Rev. 08/2006

State of Utah
Department of Workforce Services
CHANGES YOU MUST REPORT

Please remember that you are required to report changes in your situation within 10 days of the day you learn of the change. Do not delay reporting changes. Changes can affect the amount of your benefits or your eligibility. If you receive more than you are eligible to receive, you will have to repay that amount. Changes you report for one program may affect your eligibility for other programs.

YOU MUST ALWAYS REPORT:

- If you move.
- If your total household income (before anything is taken out) becomes more than: $ per month .

AND if you receive **CASH ASSISTANCE** you must also report:

- If you only have one child receiving cash assistance and that child moves out of your home.

AND If you need **FOOD STAMPS** and you are able-bodied between the ages of 18-49 with no children living in your household you must also report:

- If your employment hours fall below 20 hours per week.

AND If you receive **CHILD CARE ASSISTANCE** you must report:

- If a parent, stepparent, spouse or former spouse moves into the home, getting married, a child receiving child care moves out of the home.
- If a parent's and/or child's school schedules change so that child care is no longer needed during the hours of approved employment and/or training activities.
- No longer in an approved training or education program.
- Not meeting minimum work requirements. This includes termination of employment. (Single parents must be employed at least 15 hours per week. In two-parent households, one parent must work at least 15 hours per week while the other parent works at least 30 hours per week.)
- If you change your child care provider.

AND If you receive **MEDICAL ASSISTANCE** you must report:

- Change of an income source.
- Change of more than $25 in gross monthly income.
- Receipt of a lump sum from any source:
  - Insurance payments
  - Accident or injury awards
- Change in assets:
  - Gaining or losing a vehicle
  - Opening a bank account
- Change of more than $25 in total allowable deductions.
- Change in health insurance.
- Change in household size, living arrangements or marital status.
- Change in the type of residence such as entering or leaving an institution.

Agreement to report:

I, _____, read or had read to me the statements above. I understand those statements. I understand I must report changes in my situation within 10 days of the day I learn of the change to my local Department of Workforce Services or Bureau of Eligibility Services office. I understand I will then have 10 days to provide verification of the reported change. I understand that any false or unreported information that is discovered may result in prosecution for fraud. I understand that I may request a fair hearing if I disagree with any action made on, my case.

_____ _____
Customer Signature Date